GEORGIA DEPARTMENT OF COMMUNITY HEALTH

FISCAL YEAR 2006
ANNUAL NURSING HOME QUESTIONAIRE (ANHQ)

- IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05 and other regulations or statutes.

The chief executive officer, executive director or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a) 1, and 111-2-2-.05(1)(a) 7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

2006 NURSING FACILITY SURVEY ACCESS FORM

The 2006 Nursing Facility Survey (ANHQ) is a Microsoft Access database. You must have Microsoft Access 2000 or a later version of Access in order to open the database and complete your survey. **Microsoft Access 97 is no longer supported.**

IF YOU NEED ASSISTANCE

When you are working in the database, you may view these instructions by clicking the Help button found on each form. You can get specific instructions for any **underlined item in blue** on the form by clicking the item.

If you can't find the answer to your problem on the Help screens, check the "Frequently Asked Questions" link on the web page where you downloaded the database. This document will be updated periodically as new questions arise.

If you still have any questions after reviewing the documentation above, please contact Virginia Seery at (404) 656-0463 or by email at vseery@dch.ga.gov.

INSTRUCTIONS FOR SUBMITTING THE DATABASE

The deadline for filing the completed survey database for your facility is September 15, 2006.

Once you have completed your survey and resolved any data validation issues, you should electronically submit the survey to the Department of Community Health (DCH). ***Please do not fax or mail a hard copy***. Follow the steps below to submit your survey:

1. You must sign the Signature Form before submitting the database. The survey will not be deemed complete without an authorized signature.
2. Please be sure to print a copy of your completed forms before submission and retain a copy of the Access file for your records.
3. To submit your database, click the green Upload button on the survey opening screen and follow the on-screen instructions. Email submissions of survey databases will ***no longer be accepted***. However, you may send any supplemental documents via email to the address listed in the previous section.

Survey Completion Status – Typically, a survey will be considered complete when a signed, completed version is received by the Division of Health Planning. All requested data elements must be provided; edit check, error messages, and validation rules must be addressed or in balance; and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Division, the survey is considered a public record. DCH staff may not be able to process your survey immediately due to high volumes of survey submissions. You may follow-up a few days after submitting your survey to make sure your survey has been processed and is considered complete by the Division of Health Planning. The completed survey will be deemed complete on the day it is received by DCH even if it is processed later. The completion status of all surveys for each facility will be published on the DCH website on or after the survey due date**. It is extremely important that you retain a copy of your completed survey (both the Access database and a printed copy).**

Revising or Amending the Survey – Pursuant to Rule 111-2-2-.04(1)(e) surveys that are received and determined to be complete by the Division of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Division of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Division of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Division may also determine that additional data, information, or documentation is needed to support the proposed revisions

INSTRUCTIONS FOR COMPLETING THE SURVEY FORM

The Access database file may either be saved to a single computer or to an internal computer network. The database can be placed on a network so that multiple users can access and complete (or review) the survey at different times. Please be sure not to make copies of the database. Only one version of the database should be sent to DHP. The Access file should open automatically to an opening screen where you can select a form to complete or view. You should be able to print a blank copy of the survey from the “print” button included on each form or from the opening screen. Select your agency from the drop-down menu on the survey form. Enter your facility’s data using the survey form. Please be sure to provide an answer in every question. If the question does not apply to your agency please indicate “not applicable”. Access does not have a “save” feature like other applications. Each change you make to the form will be saved automatically.

INSTRUCTIONS FOR COMPLETING THE SIGNATURE FORM

The database contains two types of forms. The first type is the survey form described above. This form is used to collect utilization data and information. The Signature Form is where the facility’s chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The facility's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. A typed version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

The Signature Form also will identify any out of balance edit checks and any validation rule criteria that are not correct. The edit checks must be resolved before the authorized signature will be accepted by the database. For example, if your total patient counts are not in balance when requested, then the Signature Form will indicate that they are out of balance and may not accept the authorized signature until the patient counts are corrected. In other cases the database will provide a warning message to inform you that certain totals do not balance that should be in balance. Please make every effort to resolve these data issues. The form may also indicate that certain responses are not valid either for your facility

type or authorization. Unresolved issues must be addressed by an explanation in the provided comments box if the data is not changed or amended.

Data Validation Requirements – All edit and balance requirements and all required fields must be completed before the facility's administrator or chief executive can authorize the survey. You can determine if the required survey totals are in balance and that all required items are complete by clicking the "View Error Messages" button in the Data Validation Requirements section at the top of the Signature Form. This button produces the Data Validation Report containing a description of any out of balance totals and any required data items that are missing. The Data Validation Report can be printed and should be rerun until all items have been corrected. **Each item on the Data Validation Report must be corrected before the form will accept the authorized signature.**

PART A: GENERAL INFORMATION

1. **Respond as requested**. Please be sure to provide both the nursing home's **Medicaid** and **Medicare** provider numbers; **use numbers only** plus one alpha character, if appropriate.

2. **Report Period:** July 1, 2006 through June 30, 2007 is the ***required*** report period. If the facility was in operation for a full year **you must** report data for a full year. If the ownership, operation or management of the facility changed during the report period, it is the responsibility of the **current owner or operating entity** to obtain the necessary data from the prior owner or operator.

PART B: CONTACT INFORMATION

Provide the name, title, email, fax, and phone numbers of the person authorized to respond to inquiries about the responses to the survey. This person must retain a copy of the completed questionnaire or completed Access file.

PART C: OWNERSHIP, PROGRAMS & LICENSURE

If your facility submitted an Annual Nursing Home Questionnaire for 2005, the submitted 2005 information should be pre-loaded for your convenience. You are required to update the pre-loaded 2005 information with any changes occurring during the 2006 Report Period.

DEFINITIONS:

Facility Owner - refers to the person or entity that owns the building and grounds. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

Facility Operator - refers to the owner of the business accountable for the profits and losses. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

Management - refers to a specific entity that the Owner or Operator has contracted to manage the routine business. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

Lessee - refers to the entity that has rented the actual building in which the business is operated.

Sub-lessee - refers to the entity that has rented from the original lessee.

Changes - refers to any Owner or Operator changes that occurred during the report period **7/1/05 through 6/30/06** or after the last day of the Report Period. This should **NOT** reflect any change solely in administrators.

Other Health Care Facilities - refers to health care organizations such as but not limited to nursing homes, hospitals, home health agencies, ambulatory surgery centers, personal care homes, and hospices.

Organizational Affiliations - refers to your facility being affiliated with a retirement complex, a licensed personal care

home, a hospital, or a hospice. Generally, such affiliations are indicated when the facilities are on the same campus and share the same administrative control.

Special Programs:

Alzheimer's Disease Program – planned and structured array of services and daily routines for persons with Alzheimer's Disease/Dementia.

Respite Care Program – an organized program that provides care and supervision to a dependent client to sustain the family or other primary care giver by providing that person with temporary relief from the ongoing responsibility of care.

Inpatient Hospice Program – an inpatient program of specialized palliative and supportive services from terminally ill persons and their families, including medical, psycho-social, volunteer and bereavement services.

Adult Day Care Program – a program that provides adults with personal care in a protective setting outside their own homes during a portion of a 24-hour day.

PART D: BEDS AND UTILIZATION

DEFINITIONS:

Beginning Census - is the total number of patients in your facility on the last day to the previous Report Period, **6/30/05.** If your facility submitted an Annual Nursing Home Questionnaire for 2005, the patient census for 6/30/05 that was reported in the 2005 survey is pre-loaded for your convenience. **IF YOU CHANGE THIS NUMBER, YOU MUST SUBMIT A REVISED SURVEY FOR THE 2005 REPORT YEAR.**

Ending Census - is the total number of patients in your facility on the last day of the current Report Period, **6/30/06**. This field is calculated by adding the net increase in patients (admissions minus discharges) to the Beginning Census.

Admission - is the formal acceptance of a patient who is to receive inpatient services in the facility.

Discharge – is the release of a patient from the facility, who was discharged to home, transferred to another institution, or died.

Beds Set Up and Staffed – are all beds that are staffed with personnel including both occupied and unoccupied beds. Temporary changes in the number of beds due to renovations, painting, etc., do not affect bed count as reported here.

Number of total Medicare, Medicaid and Private and Other Patients - count the patients reported on the census of 6/30/2005 plus the new admissions from July 1, 2005 to June 30, 2006; then sort each patient by payment source. ***Remember,*** a patient may be included in more than one category.

Race/Ethnicity Categories: (as defined by the U.S. Census Bureau)

American Indian or Alaska Native - A person having racial origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian - A person having racial origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, but not limited to, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American – A person having racial origins in any of the Black racial groups of Africa.

Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish Origin" can be used in addition to "Hispanic" or "Latino."

Native Hawaiian or Other Pacific Islander – A person having racial origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White – A person having racial origins in any of the original peoples of Europe, the Middle East, or North Africa. Include people who indicate their race as "White" or report entries such as Irish, German, Lebanese, Near Easterner, Arab, or Polish.

Multi-Racial – A person having racial origins from two or more of the above definitions.

DIAGNOSTIC CATEGORIES:

Mental Retardation	ICD-9-CM DIAGNOSIS CODES 317-319
Mental illness/Psychoses	ICD-9-CM DIAGNOSIS CODES 290-316
Alzheimer's Disease	ICD-9-CM DIAGNOSIS CODE 331.0
HIV/AIDS	ICD-9-CM DIAGNOSIS CODES 042 and/or 079.53
Severe Physical Disability	**Persons with severe physical impairment and/or traumatic brain injury that substantially limit one or more functional activities of daily living and require assistance of another individual,**

PART E: FACILITY WORKFORCE INFORMATION:

The Division of Health Planning is collecting workforce information to support the State's workforce planning activities. The Division is currently focusing on planning efforts for Registered Nurses, Licensed Practical Nurses, Nurse Aides/Assistants, and other direct care staff. Please report the budgeted number of full-time staff (FTE) and the number of vacancies as of **June 30, 2006**.

Also, please report the average time your facility has spent during the past six months filling vacant positions. Use one of the four time periods provided for each professional category.

PART F: DAYS OF CARE FOR MEDICAID PROVIDER:

If you are a Medicaid Provider, report the inpatient days of care by provider for the state fiscal year from **7/1/2005 to 6/30/2006.**

Beginning with the state fiscal year for 2006, the Division of Health Planning is collecting inpatient services days of care for Medicaid and other payers.

Inpatient days - is defined as the care of one patient during the period between the census-taking hours of two successive calendar days. Normally, the day of discharge should not be counted as an inpatient day of care. If a patient is admitted and discharged on the same day, then one (1) day of inpatient care is assigned to that patient.

The adjective, **Service**, is used to indicate that the patient received care. The facility may or may not have received compensation for the care.

PART G: PATIENT ORIGIN:

Patient Origin – This represents the place where each patient was living prior to being admitted to your facility. This must reflect the Georgia County before he/she was admitted to your facility, or if the patient was from out-of-state, indicate where the patient was living prior to being admitted to your facility.

PART H: ELECTRONIC SIGNATURE AND CONTRACT

Please note that the survey **WILL NOT BE ACCEPTED** without the authorized signature of the Chief Executive Officer, Executive Director or Principal Administrator of the facility pursuant Rule 111-2-2-.04(1)(6).

The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

The ANHQ is due at the Department of Community Health by September 15, 2006. Submit the survey electronically using the instructions provided above. For questions regarding the ANHQ or if you are unable to submit the survey electronically, please contact Virginia Seery with the Division of Health Planning at (404) 656-0463, or vseery@dch.ga.gov .

.